Hanford Employee Welfare Trust

HEWT

Retiree Benefit Overview 2023

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 19 for more details.

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A Message from the Hanford Employee Welfare Trust

Welcome! As a retiree, or a spouse of a retiree in the Hanford Employee Welfare Trust (HEWT), you are eligible to enroll from a deferred status or make changes to your current retiree medical elections on an annual basis.

The HEWT offers you the flexibility to choose from two medical plans which we are confident will meet your needs. We look forward to continuing our relationship with you throughout the next year.

Eligibility

Eligible Participants

Eligible participants and their eligible dependents are offered medical and life insurance through their sponsoring employer. **Retiree medical plan provisions and contributions requirements are subject to change.** To qualify for this medical and/or life insurance coverage, an individual must:

- Be at least age 55 as of the last day of work;
- Have at least 10 pension vesting years;
- Be enrolled, or eligible to enroll under a HEWT-sponsored plan;
- Pay the required contributions for the elected coverage;
- Be in good standing with the sponsoring company

Note: Effective 01/01/2004, new hires are not eligible for Post-retirement Insurance.

Eligible Dependents

In addition to electing coverage for yourself, you can elect to continue coverage for your eligible dependents. Eligible dependents include your spouse or domestic partner (as recognized by Washington State, one partner must be at least 62 years or older and both partners must live in the same residence) under age 65 and your unmarried children that you provide at least 50% or more of their support and are under age 23 (UnitedHealthcare) or under age 26 (Kaiser Permanente). If your eligible dependent(s) are age 65 or older, coverage may continue under the HEWT's Medicare supplement plan.

NOTE: You are not able to add any dependents to your plan after you retire. If you defer coverage, you may only cover those listed at the time of deferral and eligible at the time you reinstate your coverage.

When Coverage Begins

Eligible retirees and their dependents can enroll:

1. During the Annual Benefits Enrollment if they have deferred coverage. Coverage for eligible retirees and dependents begins on January of the following calendar year.
2. Within 31 days of losing other coverage if they have deferred coverage, with a Certificate of Coverage form from the prior plan.

Each plan year begins on January 1st and ends on December 31st.

Opportunity to Opt-Out

A one-time opt-out option is available to you as a participant in the HEWT post-retirement medical benefits. After opting out, you may re-enroll in coverage within 31 days following a qualifying life status change or during an annual enrollment period, which is effective January 1 of the following calendar year. If coverage is dropped again for any reason, you may not re-enroll in medical coverage.

Life Status Change

A change in life status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some life status changes include:

- Divorce, legal separation or annulment
- Loss of spouse's job or change in work status where coverage is maintained through the spouse's plan (applicable if previously opted out)
- A significant change in your or your spouse's health coverage attributable to your spouse's employment (applicable if previously opted out)
- Death of a spouse or dependent
- Becoming eligible for Medicare or Medicaid during the year

If such a change occurs, you must notify the HEWT of the event and provide the requested documents within 31 days of the event to avoid a lapse in coverage. Documentation is required to verify your change of status. Please contact HEWT at Benefits-HEWT (onsite) or at Benefits-HEWT@rl.gov (offsite) to make these changes.

Cost of Coverage

How You Pay for Health Care Costs

You share the cost of health care services with the medical, dental, and vision

Premium: A premium is the total cost for your medical insurance.

Deductible: A deductible is the amount you must pay before the medical and dental plans begin sharing the cost of services. You pay this full amount, if required by your plan, before the plan pays benefits. The deductibles on the medical and dental plans accumulate on a calendar year basis.

Coinsurance: When you are paying coinsurance, you are sharing a percentage of the cost of services with the medical plan. For example, with the UHC and Kaiser plans, after you satisfy your deductible, the plan will pay 80% and you will pay 20% for many services received from in-network providers.

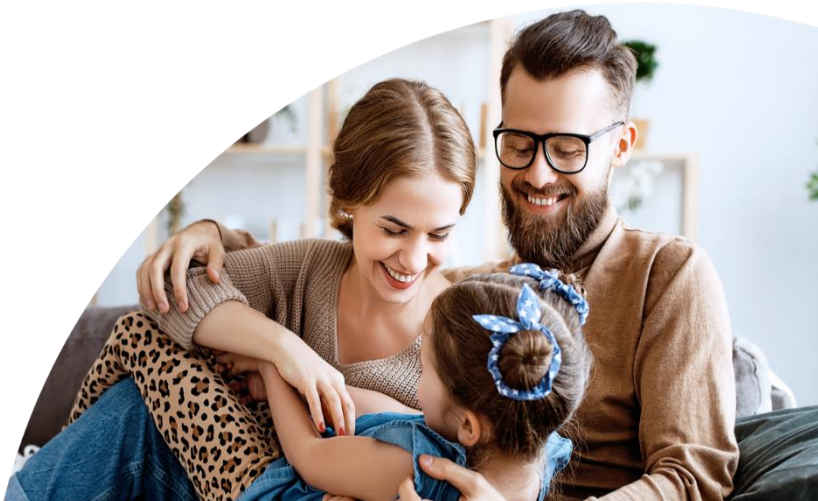
Out-of-Pocket Maximum: The calendar year out-of-pocket maximum protects you from major medical expenses. This is the most you would pay and includes your medical deductible, copays, and coinsurance, for eligible expenses during a calendar year. Once you reach the out-of-pocket maximum, the plan pays 100% of the usual, customary, and reasonable charges for the balance of the calendar year for covered care.

Your Total Costs

Remember, the total cost you pay for health care services in a plan year is the combination of your out-of-pocket costs when you access care and the premium payments you are required to make for coverage.

Premiums + Out-of-Pocket Costs = **Total Cost of Health Care**

In addition, under the HEWT plans you have access to several plan features including virtual care, a 24-hour nurse line and behavioral health.



Get More Value From Your Plans

Minimize your out-of-pocket expenses

Below are a few key points to help you get the most value out of your health plan:
Look for a Family Practice, Internal Medicine or General Practice physician. You will always save money by using providers in your medical plan's network. What are your options? You may want to consider the following the next time you need care:

For a Life-Threatening Emergency

In a true medical emergency – such as an apparent heart attack, serious injury, or other life-threatening situation – always call 911 or your local emergency number right away!

Use the Emergency Room ONLY for emergencies

For Less Critical Issues if the emergency is NOT life threatening

- Call your physician's office (even after hours, someone is typically on call to answer questions). Your doctor will know you and your medical history and may be able to schedule you for a visit the same (or next) day. You may also want to consider a virtual care option.
- If your condition starts or worsens on the weekend, or after your doctor's office has closed for the day, you may want to consider a visit to an Urgent Care facility. These clinics are not affiliated with hospitals, but they do have doctors and nurses on staff and are open in the evenings and on weekends.

If You are Traveling and You Need Urgent Care

Your medical plan covers urgent care. An urgent condition is one that requires immediate care but is not life-threatening. If you seek urgent care while traveling, you or someone acting on your behalf should notify your doctor within 48 hours of the onset of the urgent condition.

Annual physical exams and cancer screening tests are covered in full

Other Plan Considerations

Take advantage of the fact the medical plan covers 100% of scheduled annual physical exams and cancer screening tests related to the physical exam when you use an in-network provider. There's no copay or deductible, however, keep in mind that if your physician orders a test that isn't part of the scheduled preventative care exam/test, those procedures may result in some out-of-pocket expense for you. It's always a good idea to check with your doctor's office before your visit, to see what tests or exams are planned. Then, call your health plan to make sure you understand if and how those tests will be covered.

Preventive dental care is covered at 100% after any

Your dental plan is designed to provide the dental coverage you need with the features you want. You have two options available to you. Delta Dental allows you to take advantage of what the plan has to offer, including the freedom to visit the dentist of your choice; an "in-network" dentist or an "out-of-network" dentist. Willamette Dental is an EPO (Exclusive Provider Organization) providing comprehensive benefits without annual maximums or deductibles; however, you must visit a network provider. Don't forget that your preventive care – is covered at 100% under both plans after any applicable copays.

Medical Insurance Features

Virtual / Telehealth Visits

Virtual or Telehealth Visits are a convenient way for members to access care for minor medical concerns. A Virtual or Telehealth Visit lets you connect with a doctor on your mobile device or computer. If you are enrolled in the UHC plan you can log onto www.uhc.com/virtualvisits.

If enrolled in a Kaiser Permanente plan you can log onto www.kp.org to learn more about Telehealth Visits or to register so you're ready to access care. You can also access information via the Kaiser mobile app.

During a virtual visit, you will be able to speak with a doctor about your health concerns, symptoms, and treatment options. You can also obtain a prescription. Virtual or Telehealth Visits are good for non-emergent issues such as allergies, bladder or urinary tract infections, bronchitis, cough, cold, flu, fever, diarrhea, migraines, headaches, pinkeye, rashes, sinus problems, sore throat, or stomachache.

24 Hour Nurse

When you have questions about your health, it helps to have an expert available. With a 24-Hour NurseLine, you can get advice from a registered nurse with clinical experience, anytime, 24 hours a day, 7 days a week. Just call and you can ask a nurse your questions, whether you are worried about a child's fever, need help with managing a health condition like diabetes or want to ask a question about your ongoing treatment.

They can help you decide when to visit your doctor, go to an Urgent Care or visit the Emergency Room. They will assist with finding network doctors, scheduling appointments, understanding your medications and how to take them safely. It is simple and there is no additional cost to you. Just call the number on your health plan ID card or sign into your medical plan. For UnitedHealthcare members, use the number on your ID card, or for Kaiser members, go to kp.org to connect with the 24-Hour Nurse specific to your plan or via the Kaiser mobile app.

Carrier Mobile Applications

The UHC Health4Me App and the Kaiser Mobile App are designed to provide access to your health information wherever you go. Whether traveling or just away from home, the apps keep your health information at your fingertips. Download the applicable medical plan app to your smartphone and you'll get instant access to view your health plan details, generate a health plan ID card, check your claim status, or find a doctor. You can also compare costs and see provider reviews, find pharmacies, and fill prescriptions. To download, log on to UHC.com or KP.org/mobile.

Medical Insurance Options

Kaiser Permanente Options Plan

The Kaiser Permanente Option provides you with flexibility when seeking covered medical services by allowing you to receive care in or outside of the Kaiser Permanente network. You will be required to elect a primary care physician (PCP) and you maximize your coverage by having care provided or referred by your PCP. This plan offers members a combination of in-network managed services and out-of-network services, which can be from any qualified provider. In-network services usually require a 20% co-insurance after the deductible is met. Out-of-network services are subject to a higher annual deductible and a co-insurance payment, typically 30% of the remaining covered expenses up to an annual out-of-pocket maximum. Prescription drug benefits through Kaiser Permanente include retail and home delivery options.

UnitedHealthcare PPO Plan

UnitedHealthcare PPO has access to a broad network of physicians and hospitals nationwide. This plan design offers a lower deductible and higher level of benefit when utilizing in-network providers. The plan includes a full spectrum of covered services and direct access to specialists without requiring a referral. Express Scripts, Inc manages the prescription drug benefit under this program. Retail and home delivery services are available.

	UnitedHealthcare PPO		Kaiser Permanente Options	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible (deductible applies unless otherwise noted)				
Individual / Family	$400 / $800	$600 / $1,200	$200 / $600	$400 / $1,200
Coinsurance	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%
Calendar Year Out-of-Pocket Maximum				
Individual / Family	$2,000 / $4,000	$4,000 / $8,000	$2,000 / $6,000	$6,000 / $18,000
Lifetime Maximum				
Per person	$1,500,000 (Combined in & out of network)		$2,000,000 (Combined in & out of network)	
Physician Office Visit				
Primary, Specialty, and Urgent Care Office Visits	Plan pays 80%	Plan pays 60%	Plan pays 80%	After a $5 copay Plan pays 60%
Preventive Care				
Adult Periodic Exams and Well Child Care	Plan pays 100% (DW)	Plan pays 40%	Plan pays 100% (DW)	Not covered
Diagnostic Services				
X-ray, Lab & Complex Radiology	Plan pays 80%	Plan pays 60%	Plan pays 80% (PA RQD for complex)	Plan pays 60% (PA RQD for complex)
Emergency Room (Copay waived if admitted)	$150 copay then Plan pays 80%	$150 copay then Plan pays 80%	$150 copay then Plan pays 80%	$150 copay then Plan pays 80%
Inpatient Hospital Facility Charges	$250 copay then Plan pays 80% (PN RQD)	Plan pays 60% (PN RQD)	Plan pays 80% (PA RQD)	Plan pays 60% (PA RQD)
Outpatient Facility Charges	Plan pays 80%	Plan pays 60%	Plan pays 80%	After a $5 copay Plan pays 60%

DW = Deductible Waived PA RQD = Pre-Authorization Required or benefits may not be covered; PN RQD = Pre-Notification Required or benefits are reduced

	UnitedHealthcare PPO		Kaiser Permanente Options	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health & Substance Abuse				
Inpatient	$250 copay then Plan pays 80% (PN RQD)	$250 copay then Plan pays 60% (PN RQD)	Plan pays 80% (PA RQD)	Plan pays 60% (PA RQD)
Outpatient	Plan pays 80% (PN RQD)	Plan pays 60% (PN RQD)	Plan pays 80%	After $5 copay Plan pays 60%
Rehabilitation Services (Occupational, Speech & Physical)				
Inpatient	Plan pays 80% (PN RQD)	Plan pays 60% (PN RQD)	Plan pays 80% (PA RQD)	Plan pays 60% (PA RQD)
			60 days per calendar year	
Outpatient	Plan pays 80%	Plan pays 60%	Plan pays 80%	After $5 copay Plan pays 60%
	Limited to 30 visits per calendar year 20 visits for cardiac & pulmonary		60 visits per calendar year	
Other Services				
Ambulance Services (Emergency Only)	Plan pays 80%	Plan pays 80%	Plan pays 80% (DW)	Plan pays 80% (DW)
Chiropractic	Plan pays 80%	Plan pays 60%	Plan pays 80%	After $5 copay Plan pays 60%
	(Limited to 20 visits per calendar year)		(Limited to 10 visits per calendar year)	
Home Health Services	Plan pays 80% (PN RQD)	Plan pays 60% (PN RQD)	Plan pays 100% (PA RQD)	Plan pays 60% (PA RQD)
	(Limited to 40 visits per calendar year)			
Hospice Services	Plan pays 100% (PN RQD)	Plan pays 100% (PN RQD)	Plan pays 100% (PA RQD)	Plan pays 60% (PA RQD)
Hearing Benefits				
Exam	Plan pays 80%	Plan pays 60%	Plan pays 80%	After $5 copay Plan pays 60%
	(1 exam every 12 months)			
Hardware	Plan pays 80%	Plan pays 60%	Not covered	Not covered
	(Plan pays up to $300 every 36 months)			
Vision Benefits				
Vision Exam	Not covered	Not covered	Plan pays 100% (1 every 12 months)	Not covered
Optical Hardware	Not covered	Not covered	Not covered	Not covered

PA RQD = Pre-Authorization is required, or benefits may not be covered. PN RQD = Pre-Notification is Required, or benefits are reduced.

Additional Services

Additional behavior health services are available to you through either the UnitedHealthcare or Kaiser Permanente Plans. These include:

Talkspace for UnitedHealthcare Members

With Talkspace online therapy, you can regularly communicate with a therapist from your phone or desktop. No office visit is required. You can message a licensed therapist or schedule live video sessions. Download the Talksapce app on your mobile phone and register (first visit only) and choose a provider at talkspace.com/connect.

Calm App for Kaiser Permanente Members

Kaiser members can use the Calm app. It is designed to use daily, providing meditation techniques and mindfulness to help lower stress, reduce anxiety and improve sleep quality. With guided meditations, programs taught by world-renowned experts, sleep stories narrated by celebrities, mindful movement videos, and more.

MyStrength App for Kaiser Permanente Members

myStrength offers Kaiser members personalized programs with interactive activities, daily health trackers to monitor and maintain your progress, and in-the-moment coping tools. It's designed to help you set goals and work towards them in ways that work for you – by making positive changes that support your mental, emotional, and overall well-being.

Kaiser Living Well Programs

Do you have an ongoing health condition?

The Kaiser Living Well programs can provide you strategies to manage and cope with conditions like diabetes, heart disease, asthma, paid and more. You'll build skills to take care of yourself and improve your well-being. You will meet others experiences similar health challenges. Together, you'll learn how to complete small, achievable steps toward Living Well. Register online at kp.org/wa/livingwell or call 800-992-2279.

Prescription Drug Coverage

UnitedHealthcare PPO/Express Scripts		
	In-Network	Out-of-Network
Prescription Out-of-Pocket Maximum	$1,500 per person	
Retail Pharmacy (up to a 34-day supply)		
Generic	$15 copay	Contact Express Scripts for Reimbursement Details
Preferred Brand Name	$35 copay	
Non-Preferred Brand Name	$50 copay	
Mail-Order Pharmacy (up to a 90-day supply)		
Generic	$30 copay	Not covered
Preferred Brand Name	$70 copay	Not covered
Non-Preferred Brand Name	$100 copay	Not covered

Kaiser Permanente Options		
	In-Network	Out-of-Network
Prescription Out-of-Pocket Maximum	Combined with Medical	
Retail Pharmacy (up to a 30-day supply)		
Preferred Generic	$20 copay	$25 copay
Preferred Brand Name	$40 copay	$45 copay
Non-Preferred Generic/Brand Name	$60 copay	$65 copay
Mail-Order Pharmacy (up to a 90-day supply)		
Preferred Generic	$40 copay	Not covered
Preferred Brand Name	$80 copay	Not covered
Non-Preferred Generic/Brand Name	$120 copay	Not covered

Monthly Healthcare Contributions

Refer to the tables below for your monthly contributions as of January 1, 2023.

Participant Under age 65 Retiree / Spouse / Dependent				
	Kaiser Permanente	UnitedHealthcare	Kaiser COBRA	UHC COBRA
Retiree	$336.00	$768.00	$982.10	$2,240.53
Retiree + 1	$672.00	$1,536.00	$1,964.19	$4,481.06
Retiree + more than 1	$1,008.00	$2,304.00	$2,946.29	$6,721.60
Participant Under age 65 and Enrolled in Medicare Parts A & B (Must submit a copy of Medicare card to HEWT Administration)				
	Kaiser Permanente	UnitedHealthcare	Kaiser COBRA	UHC COBRA
Participant	$211.00	$483.00	$982.10	$2,240.53

Dental Insurance

Dental coverage for retirees is only available through COBRA continuation if the retiree had dental coverage at the time of retirement. If you had dental coverage at the time of retirement, you will receive a packet from HealthEquity shortly after your last day of employment. Please contact HealthEquity at 877-722-2667 for benefit and enrollment details. You may continue COBRA for 18 months.

Dental (Monthly COBRA Rates)		
	Delta Dental of WA (COBRA)	Willamette Dental of Washington, Inc. (COBRA)
Individual	$46.01	$52.22
Individual + 1	$83.17	$104.65
Individual + more than 1	$123.07	$196.10

USI MyBenefits2Go Mobile Application

New

FIND IT IN THE APP STORE!

Access all your benefit insurance policy details and contact information on the go! The free application will provide you with:

- The HEWT Benefit Guide Overview
- Organized plan information in one place
- Plan Summaries and SBC's
- Policy Numbers
- Ability to store photos of your ID cards from your benefit plans
- Carrier contact information
- The HEWT Human Resources team contact information

It is easy to install. From your App store, search for MyBenefits2Go.

When prompted, enter the code **A96195** to access The HEWT benefit details.

The app is a quick and simple way for you and your enrolled dependents to access benefit summaries and other import information about the HEWT plans. The app automatically connects you with the most updated information.

Contact Information

	ADDRESS	PHONE NUMBER	WEBSITE / E-MAIL
UnitedHealthcare Inc. Medical PPO Group #: 702633	PO Box 30555 Salt Lake City, UT 84130	Customer Service & Pre-Admission Phone: 866-249-7606 Fax #: 801-567-5499	www.uhc.com www.myuhc.com www.uhcprovider.com
Express Scripts, Inc. Prescription Drugs (Retail and Home Delivery)	Express Scripts, Inc. (Retail & Home Delivery)	Customer Service Phone: 800-796-7518	www.express-scripts.com
Accredo Specialty Prescription Drugs (Specialty)	1620 Century Center Parkway, Ste 109 Memphis, TN 38134	Customer Service: Phone: 800-803-2523	www.accredo.com
Kaiser Permanente Medical Options & Vision Retirees #6813900	5615 W Sunset Highway Spokane, WA 99223	Customer Service: Phone: 888-901-4636	www.kp.org/wa
Kaiser Permanente Prescription Drugs	5615 W Sunset Highway Spokane, WA 99223	Customer Service: Phone: 888-901-4636 Mail Order: 800-245-7979	www.kp.org/wa/pharmacy
Willamette Dental Group Managed Dental Group # WA79	6950 NE Campus Way Hillsboro, OR 97124	Customer Service: Phone: 855-433-6825	www.willamettedental.com
Delta Dental of Washington Dental PPO Group #00522	PO Box 75688 Seattle, WA 98175	Customer Service: Phone: 800-554-1907	www.deltadentalwa.com
HealthEquity COBRA	15 W. Scenic Pointe Dr. Draper, UT 84020	Customer Service: Phone: 877-722-2667	www.mybenefits.wageworks.com
HEWT Retiree Benefits Administration **Hanford Mission Integration Solutions (HMIS)**	PO Box 943, H2-23 Richland, WA 99352	Tiffany Orr (A-K) Phone: 509-376-0623 Teresa Roske (L-Z) Phone: 509-376-1918 Survivor Benefits Phone: 509-376-5200	Website: www.hmis.hanford.gov/hr E-mail Benefits-HEWT (Onsite) Benefits-HEWT@rl.gov (Offsite)
Hanford Retiree Association Paul Vinther, President	PO Box 768 Richland, WA 99352-0768	Phone: 509-943-1747	
Medicare Administration	Medicare Contact Center PO Box 1270 Lawrence, KS 66044	Phone: 800-633-4227	www.medicare.gov
Healthy Ages (Kadlec Hospital Sponsored)		Assistance w/ Medicare Medical Claims Mon – Thurs (8am – 4pm) Phone: 509-942-2700	
Towers Watson Via Benefits (Over-Age 65 Providers)		Phone: 888-864-0764	www.my.viabenefits.com/hewt

This brochure summarizes the benefit plans that are available to HEWT - Hanford Employee Welfare Trust eligible retirees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

UnitedHealthcare: $400 in-network individual deductible, 80%/20% coinsurance.
Kaiser Permanente: $200 in-network individual deductible 80%/20% coinsurance.

PATIENT PROTECTION MODEL DISCLOSURE

If a medical benefit option offered under the Hanford Employee Welfare Trust (HEWT) requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, the Plan will designate one for you until you make a designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, refer to the applicable certificate of coverage or Summary Plan Description (SPD). For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, refer to the applicable certificate of coverage or SPD.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Rhonda Renz
509-372-8284
Rhonda_J_Renz@rl.gov

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY YOUR HEALTHCARE PLANS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases, we never share your information unless you give us written permission: Marketing purposes and sale of your information.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective January 1, 2022
- If you have any questions regarding this notice or HIPAA privacy requirements as pertaining to the Health Plan, please contact: Rhonda Renz, HEWT HIPAA Privacy Office at 509-372-8284 or at Hanford Mission Integration Solutions (HMIS), LLC, MSIN H2-23, P.O. Box 943 Richland, WA 99352-1000

Important Notice from The Hanford Employee Welfare Trust (HEWT) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The HEWT and about your options under Medicare's prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **The HEWT has determined that the prescription drug coverage offered by Express Scripts, Inc., and Kaiser Permanente is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current HEWT-sponsored drug coverage will be affected. The HEWT currently includes prescription drug coverage with the medical plans it offers to Medicare-eligible retirees and Long-Term Disability participants. If you choose to enroll in Medicare Part D, you will no longer be eligible for prescription drug coverage from The HEWT.

If you do decide to join a Medicare drug plan and drop your current HEWT-sponsored prescription drug coverage, be aware that you and your dependents will not be able to take this coverage back until the HEWT Annual Enrollment Period in October of any year for coverage effective January 1st of the following year.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with HEWT and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact Benefits Administration for further information at 509-372-8284 or by e-mail to BenefitsHEWT@rl.gov (offsite) or Benefits-HEWT (onsite).

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the HEWT changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2023
Name of Entity/Sender:	Hanford Employee Welfare Trust (HEWT)
Contact--Position/Office:	Rhonda Renz, Benefits Administrator / HMIS – Benefits Administration
Address:	PO Box 943, H2-23, Richland, WA 99352
Phone Number:	509-372-8284

Premium Assistance Under Medicaid and the

Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)